FBMC
proven benefit solutions
P.O. Box 1878 Tallahassee, FL 32302-1878

STATE OF VERMONT
ENROLLMENT/FAMILY CHANGE IN STATUS FORM

Complete the Enrollment Form only if you want to establish or continue a tax-free Medical Expense and/or Dependent Care Flexible Spending Account (FSA).

Plan Year: January 1 — December 31

Press hard with a ballpoint pen. Do not use carbon paper. All boxes in this section should be completed.

Name (Please Print) Last	First	MI	Social Security #	Employee ID #

Home Address Street	City	State	ZIP

Daytime Phone	Home Phone	Date of Hire	Date of Birth	Annual Salary
( )	( )			

ENROLLMENT STATUS ☐ REENROLLMENT ☐ NEW HIRE ☐ CHANGE IN STATUS

FOR USE BY EMPLOYEE BENEFITS AND WELLNESS DIVISION

Coverage Effective Date	First Deduction Date

Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below. Complete the worksheets provided in your Flexible Benefits Reference Guide before deciding on the amount. If you have questions, consult your Reference Guide, or call FBMC Customer Service at 1-800-342-8017.

In Box #1, indicate the dollar amount you elect to contribute for the plan year. In Box #2, indicate the number of regular payroll checks you expect to receive during the plan year. (Employees enrolling during Open Enrollment will receive 26 paychecks for the plan year.) In Box #3, indicate the deduction amount per paycheck. (Note: if Box #2 multiplied by Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding.) By signing this form, you certify that you expect to receive the number of paychecks listed in Box #2. If appropriate, decrease the number to allow for anticipated unpaid leave, planned retirement or any other anticipated leave or event.

MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT

Receive reimbursement for eligible medical expenses incurred by you, your family members or both. [Maximum allowable contribution is $5,000; Minimum is $130.]

Box #1 Total Plan Year Dollar Amount from Line 2 of your Worksheet		_____
Box #2 Number of Regular Paychecks Expected (26)	÷	_____
Box #3 Reduction Per Regular Paycheck	=	_____

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

TAX FILING STATUS [PLEASE CHECK ONE]: Minimum is $130 per year.

☐ **Married, filing separately [maximum - $2,500]** ☐ **Married, filing jointly [maximum - $5,000]** ☐ **Single, head of household [maximum - $5,000]**

Box #1 Total Plan Year Dollar Amount from Line 3 of your Worksheet		_____
Box #2 Number of Regular Paychecks Expected (26)	÷	_____
Box #3 Reduction Per Regular Paycheck	=	_____

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before federal, state and Social Security taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand the contribution to my Social Security account will be reduced since contributions will be based on my income after deductions.
- I understand that any amount remaining in any FSA that is not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- I understand that the funds in one FSA cannot be used to reimburse expenses covered by another FSA.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax returns.
- I understand that the funds in any FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand that the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment or file an approved Change in Status before the end of the plan year.
- I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate in the plan during the upcoming plan year.
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any additional source and 4) I will collect and maintain sufficient documentation to validate the foregoing.

Employee Signature	Date Signed

Submit your completed enrollment form to: 144 State Street, Montpelier, VT 05620.